

School Medical Report

Last Name	First Name	School	Grade
Birthdate	Birthplace	Sex	Phone
Parent's Name (or Guardian)		Address	Zip Code

Illness

Allergy	Measles (red)
Chickenpox	Mumps
Diabetes	Rheumatic Fever
Epilepsy	Tuberculosis
Rubella	Whooping Cough
Other Illnesses and Surgery	
Blood Lead Test Pos _____ Neg _____ Date _____	
Tuberculin Test: Date _____ Pos _____ Neg _____	
Other tests _____	

Please attach copy
of
immunizations.

✓ = normal or negative

Physical Examination

Appearance _____	Ears _____	Hernia _____
Posture _____	Nose _____	Back _____
Nutrition _____	Throat _____	Extremities _____
Development _____	Lymph Nodes _____	Blood Pressure _____
Neurological _____	Thyroid _____	Urine Analysis _____
Speech Defect _____	Heart _____	Hemoglobin _____
Skin _____	Lungs _____	Height _____
Hair & Scalp _____	Abdomen _____	Weight _____
Eyes & Vision _____	Genitalia _____	Other _____

Chronic Disease _____ Medications _____

Remedial Defects _____

Physical Education Program: Full _____ Limited _____ None _____

Reason for Limitation _____

Physician's Comments & Recommendations: _____

Important Medical Information _____

Date of Exam _____ Physician _____